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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01032

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH COUNTY Talbot MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN St. Michaels, LENGTH OF STAY (in this place) Life				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Talbot CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN St. Michaels, STREET ADDRESS (If rural give location) 1			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Tyrone Westley Cannon				4. DATE OF DEATH (Month) (Day) (Year) 1 15 1956			
5. SEX M	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) -	8. DATE OF BIRTH 8/9/55	9. AGE last birthday Yrs. 5	IF UNDER 1 YEAR Months 5 Days 6	IF UNDER 24 HRS. Hours 6 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) St. Michaels, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Wilson Cannon				14. MOTHER'S MAIDEN NAME Doris Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) -		16. SOCIAL SECURITY NO. -		17. INFORMANT & ADDRESS Wilson Cannon			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 491X IMMEDIATE CAUSE (A) Broncho pneumonia				INTERVAL BETWEEN ONSET AND DEATH 3 days			
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____							
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 12:15 P.M. from the causes and on the date stated above.							
SIGNATURE R. Lane Wrath				ADDRESS (Street, city, town, state) St. Michaels		DATE SIGNED 1-16-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1/17/56		NAME OF CEMETERY OR CREMATORY New Colored Cemetery		LOCATION (City, town, or county) St. Michaels, Talbot, Md.	
24. REC'D BY REGISTRAR DATE 1 7 1956		REGISTRAR'S SIGNATURE Mrs. R. R. Seths		25. FUNERAL DIRECTOR'S SIGNATURE Norman D. Marshall		ADDRESS St. Michaels, Md.	

CERTIFICATE OF DEATH

Reg. Dist. No.

TO BE COMPLETED BY PHYSICIAN

NAME OF DECEASED

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1956

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14, Film 192 2-7-56 et

01033

1955

CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>			
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>40 EASTON</u>		LENGTH OF STAY (in this place) <u>7 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Queen Anne 17A-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>80 Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Mrs. LOWANNA COOPER</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>1 22 1956</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Jan 5-1872</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Mr. Samuel Fox</u>				14. MOTHER'S MAIDEN NAME: <u>Henrietta Cox</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mr. William H. Crofts, Sr. Queen Anne's</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE <u>332X</u>				(A) <u>Cerebral malacia</u>			
ANTECEDENT CAUSE (S)				(B) <u>Myocardial scarring</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C) <u>Advanced arteriosclerosis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/4</u> , 19 <u>56</u> , to <u>1/22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/22</u> , 19 <u>56</u> , and that death occurred at <u>7:45 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Edmund</u>		M. D. <u>Carlton</u>		DATE SIGNED <u>23 Jun 1956</u>			
23. BURIAL CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>1/25/56</u>		NAME OF CEMETERY OR CREMATORY <u>Landing Neck</u>		LOCATION (City, town, or county) (State) <u>Easton Md R.I.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/23/56</u>		REGISTRAR'S SIGNATURE <u>N. H. Neenan</u>		24. FUNERAL DIRECTOR <u>Carlton</u>		ADDRESS <u>Carlton</u>	

BUREAU V. S.

JAN 30 1956

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01034

1956

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Euston</u>		LENGTH OF STAY (in this place) <u>8 da.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Euston</u>		<u>40</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>5 South Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Lily Mae Dawkins</u>				OF DEATH: <u>1-6</u> 19 <u>56</u>			
5. SEX: <u>Fe</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>Feb 26, 1883</u>	9. AGE last birthday: <u>72</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY: <u>EW</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Mr. Charles Leverton</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Elizabeth Thompson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mr. Edmund K. Dawkins</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myocardial Infarct</u>							
ANTECEDENT CAUSE (B) <u>Coronary Thrombosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1097-109156</u> , 19 <u>56</u> , to <u>11-26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 7, 1956</u> , and that death occurred at <u>11:26</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M. D. <u>[Signature]</u>		DATE SIGNED <u>Jan 9, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>Jan 9, 56</u>		NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		LOCATION (City, town, or county) (State) <u>Easton</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-7-56</u>		REGISTRAR'S SIGNATURE <u>N.A. Neerix</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>Easton Md</u>	

BUREAU V. S.

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INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1076

CERTIFICATE OF DEATH

01035

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>talbot</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>talbot</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Easton</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFD #2</u>				STREET ADDRESS (If rural give location) <u>RFD no 2</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>George</u>		(Middle) <u>W.</u>		(Last) <u>Dobson</u>		(Month) <u>1</u> (Day) <u>20</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>3/27/86</u>	
9. AGE last birthday <u>69</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jake Dobson</u>		14. MOTHER'S MAIDEN NAME <u>Sally Price</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>215-20-2018</u>		17. INFORMANT & ADDRESS <u>William Dobson, Barton, Md.</u>		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Heart Failure</u>						<u>6 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>						<u> yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-17</u> , 19 <u>56</u> , to <u>1-20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-20</u> , 19 <u>56</u> , and that death occurred at <u>3:00</u> M., from the causes and on the date stated above.							
SIGNATURE <u>W. H. Bull</u>				ADDRESS (Street, city, town, state) <u>Barton, Md.</u>		DATE SIGNED <u>1-23-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/23/56</u>		NAME OF CEMETERY OR CREMATORY <u>Richards Cem.</u>		LOCATION (City, town, or county) (State) <u>Barton, Md.</u>	
24. REC'D BY REGISTRAR <u>1/21/56</u>		REGISTRAR'S SIGNATURE <u>N. H. Newies</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Donnell</u>		ADDRESS <u>Barton, Md.</u>	

CERTIFICATE OF DEATH

1956

Reg. Dist. No.

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BUREAU V. S.

JAN 30 1956

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1957

CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>TALBOT</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Laraine</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>40 EASTON</u>		LENGTH OF STAY (in this place) <u>36 hrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>PRESTON</u>		<u>05X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>80 EASTON Memorial Hosp.</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Stella FOSTER</u>				<u>1 18 1956</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>MARCH 15 1908</u>	9. AGE last birthday <u>47</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>H.W.</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>	
13. FATHER'S NAME: <u>Joseph Stevens</u>				14. MOTHER'S MAIDEN NAME: <u>Josephine Wing</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <u>Emmons Nelson Fales (husb)</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Heart failure</u>							
ANTECEDENT CAUSE (B) <u>Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/16</u> , 19 <u>56</u> , to <u>1/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/18</u> , 19 <u>56</u> , and that death occurred at <u>5:20</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M. D. <u>[Signature]</u>		ADDRESS <u>Easton</u>		DATE SIGNED <u>19 Jan 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal - Burial</u>		DATE THEREOF <u>1/24/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Cemetery</u>		LOCATION (City, town, or county) (State) <u>R.F.D. #1 Cambridge, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/22/56</u>		REGISTRAR'S SIGNATURE <u>H. H. Neerius</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>Cambridge, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 30 1956

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01037

CERTIFICATE OF DEATH

Item 5, FilmGL92 2-15-56 et

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (If in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural Easton</u>		<u>8 mo.</u>		TOWN <u>Rural Easton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
13. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Della</u> (Middle) <u>Henley</u> (Last) <u>Gallup</u>				(Month) <u>Jan.</u> (Day) <u>28</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>May 19, 1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
					Months <u>8</u> Days <u>9</u>	Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<u>Housekeeper</u>		<u>At home</u>		<u>Princess Anne County, Va.</u>		<u>U.S.</u>	
13. FATHER'S NAME <u>William James Henley</u>				14. MOTHER'S MAIDEN NAME <u>Emma Basier</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Mrs. Henry L. Heinemann</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420. IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 Hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u>				<u>2 Mos.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertensive disease</u>				<u>2 yrs.</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Jan. 28, 1956</u> , to <u>Jan. 28, 1956</u> , that I last saw the deceased alive on <u>Jan. 28, 1956</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. Tyler Baker</u> M.D.				ADDRESS (Street, city, town, state) <u>Easton, Md.</u>		DATE SIGNED <u>29 Jan 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>Jan 29, 56</u>		<u>Easton Home Chapel</u>		<u>Virginia Beach, Va.</u>	
24. RECD BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Jan 29, 56</u>		<u>N.A. Neer</u>		<u>Robert E. Easton</u>		<u>Easton Md</u>	

CERTIFICATE OF DEATH

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See Ord. No. 37

3. DEATH RECORDS (HOSPITALS)

4. PLACE OF DEATH

5. DATE OF DEATH

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ENCLOSURE

BUREAU V. S.

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01038

1078

CERTIFICATE OF DEATH

Reg. Dist. No. 291...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>talbot</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Bellvue</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Bellvue md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 17</u>				STREET ADDRESS (If rural give location) <u>P.O. Box 17</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Frank Easter Green</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> <u>20</u> <u>1956</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>col</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>married</u>	8. DATE OF BIRTH: <u>6/12/187</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>waterman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Oyster</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>George W. Green</u>				14. MOTHER'S MAIDEN NAME: <u>Helen Brummel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs Frank Green, Bellvue Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cardiac Asthma</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/12</u> , 19 <u>54</u> to <u>1/2</u> , 19 <u>56</u> that I last saw the deceased alive on <u>12/25</u> , 19 <u>55</u> , and that death occurred at <u>1130 AM</u> , from the causes and on the date stated above. SIGNATURE <u>Dr. Perkins</u> ADDRESS <u>M.D. Royal Oak Md</u> DATE SIGNED <u>15-56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/8/56</u>		NAME OF CEMETERY OR CREMATORY <u>Royal oak Cem</u>		LOCATION (City, town, or county) (State) <u>Royal oak MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 7, 1956</u>		REGISTRAR'S SIGNATURE <u>Mrs Robt H. Suk</u>		24. FUNERAL DIRECTOR <u>James B. Darwell</u>		ADDRESS <u>Easton Md</u>	

Dr. Perkins

BUREAU V. S.

JAN 11 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01039 290...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>TALBOT</u> MARYLAND		CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>EASTON</u>		STATE <u>Maryland</u> COUNTY <u>Queens Anne's</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lenteville</u> 17K-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hsp.</u>		LENGTH OF STAY (in this place) <u>14 days</u>		STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) SARA HANCOY				4. DATE (Month) (Day) (Year) OF DEATH: 1 13 1936			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Joseph Royal</u>				14. MOTHER'S MAIDEN NAME: <u>Virginia Wilson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Edna Burns, (nee) Easton</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Intra-cranial hemorrhage</u>							
ANTECEDENT CAUSE (S) DUE TO <u>Coronary artery</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Hypertension</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased alive on 19....., and that death occurred at 4:10 P M, from the causes and on the date stated above.							
SIGNATURE <u>Edna Burns</u>		M. D. <u>Easton</u>		DATE SIGNED <u>17 June 1936</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-16-56</u>		NAME OF CEMETERY OR CREMATORY <u>Wye Mills</u>		LOCATION (City, town, or county) (State) <u>Wye Mills Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-14-56</u>		REGISTRAR'S SIGNATURE <u>N.H. Neer</u>		24. FUNERAL DIRECTOR <u>James D. Cahill</u>		ADDRESS <u>Easton, Md.</u>	

U.S. AIR FORCE
CONGRESS

RECEIVED
JAN 30 1956
BUREAU V. S.

This is all
the information
that could
be obtained

H P Hammer of
Memorial Hospital



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01040

1079

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Talbot</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Talbot</i>			
CITY (If outside corporate limits, write RURAL OR TOWN <i>Royal Oak</i>)		LENGTH OF STAY (in this place) <i>54 years</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Royal Oak</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) <i>Fredrick</i> (Middle) <i>Harper</i> (Last) <i>Harper</i>				4. DATE OF DEATH: (Month) <i>Jan.</i> (Day) <i>15</i> (Year) <i>1956</i>			
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <i>married</i>	8. DATE OF BIRTH: <i>Oct. 2 1871</i>	9. AGE last birthday: <i>84</i> yrs.	IF UNDER 1 YEAR: Months _____ Days _____		IF UNDER 24 HRS.: Hours _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life. even if retired) <i>Farmer</i>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Battle Creek Mich.</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.</i>	
13. FATHER'S NAME: <i>John Harper</i>				14. MOTHER'S MAIDEN NAME: <i>unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. _____		17. INFORMANT & ADDRESS: <i>Mrs. Newman Callink Bellevue Md.</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>myocardial infarction</i>						6 hr	
ANTECEDENT CAUSE (B) <i>arteriosclerotic coronary heart d.</i>						-	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>abdominal aneurysm</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: _____		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR? <i>fall</i>			
22. I hereby certify that I attended the deceased from <i>1-10</i> , 19 <i>56</i> to <i>1-15</i> , 19 <i>56</i> that I last saw the deceased alive on <i>1-15</i> , 19 <i>56</i> , and that death occurred at <i>6:45</i> PM, from the causes and on the date stated above.							
SIGNATURE <i>John Michael</i>				ADDRESS <i>St Michaels Md.</i>		DATE SIGNED <i>1-18-56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Jan. 18, 1956</i>		NAME OF CEMETERY OR CREMATORY <i>Spring Hill Cemetery</i>		LOCATION (City, town, or county) (State) <i>Easton Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Jan 18 1956</i>		REGISTRAR'S SIGNATURE <i>Mrs. Robert R. Beck</i>		24. FUNERAL DIRECTOR <i>Maureen C. Newman</i>		ADDRESS <i>Don</i>	

BUREAU V. S.

JAN 24 1936

RECEIVED

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CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>40 EASTON</u>		LENGTH OF STAY (In this place) <u>20 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>GREENSBORO</u> <u>05X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>80 Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Mrs. Susie Ingersoll</u>				<u>1 22 1956</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>March 9 1878</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME: <u>Jenkins</u>				14. MOTHER'S MAIDEN NAME: <u>Charlotte Taylor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs. Claude L. Ingersoll son Greenville Delaware</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Subarachnoid Hemorrhage</u>				<u>2 months</u>			
ANTECEDENT CAUSE (S) (B) <u>a-c.v.d.</u>				<u>?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/2</u> , 19 <u>56</u> , to <u>1/22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/22</u> , 19 <u>56</u> and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M. D. <u>Easton</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>1/25/56</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons</u>		LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/23/56</u>		REGISTRAR'S SIGNATURE <u>N.A. Neerue</u>		24. FUNERAL DIRECTOR <u>George C. Thig</u>		ADDRESS <u>Salisbury, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 30 1956

BUREAU V. S.

1059

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Talbot</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Queen Anne</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>40 Easton</i>	LENGTH OF STAY (in this place) <i>11 days</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Grasonville 16x-2</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>80 Memorial Hospital</i>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) <i>James</i> (Middle) <i>B.</i> (Last) <i>Hess</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>1 20 1956</i>	
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <i>Widowed</i>	8. DATE OF BIRTH: <i>June 28, 1869</i>
		9. AGE last birthday <i>86</i> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <i>Maryland</i>
			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME: <i>James B Hess</i>		14. MOTHER'S MAIDEN NAME: <i>Anna Marie Friel</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS: <i>Mrs Clara E. Lyntal Grasonville Md</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Heart failure</i>			
ANTECEDENT CAUSE (S) DUE TO <i>Arteriosclerotic heart disease</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1/9</i> , 19 <i>56</i> , to <i>1/20</i> , 19 <i>56</i> that I last saw the deceased alive on <i>20</i> , 19 <i>56</i> , and that death occurred at <i>12:30</i> P.M. from the causes and on the date stated above.			
SIGNATURE <i>[Signature]</i>		DATE SIGNED <i>27 Jan 1956</i>	
		M. D. <i>Caston</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>1/23/56</i>	
		NAME OF CEMETERY OR CREMATORY <i>St. Peters</i>	
		LOCATION (City, town, or county) (State) <i>Queenstown Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>1/20/56</i>		REGISTRAR'S SIGNATURE <i>N. H. Meriv</i>	
		24. FUNERAL DIRECTOR <i>Barton Ben. Cottrell</i> ADDRESS <i>Maryland</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 30 1956

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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1961

Item 11, Film G191 1-16-56 et

CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Easton</u>		LENGTH OF STAY (in this place) <u>1 1/2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bellevue</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>/</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Robert</u> <u>Johnson</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 1</u> <u>1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Jan 10 1896</u>	9. AGE last birthday: <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Palmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Palmer</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Alec Johnson</u>				14. MOTHER'S MAIDEN NAME: <u>Sallie Carter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>0</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Martha Johnson (wife)</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>443X</u>							
ANTECEDENT CAUSE (S) <u>Apoplexy</u>						<u>2 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>H.C.V.D.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/30/1955</u> , to <u>1/1/1956</u> , that I last saw the deceased alive on <u>Jan. 1</u> , 1956, and that death occurred at <u>8:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>1-1-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-3-56</u>		NAME OF CEMETERY OR CREMATORY <u>Bellevue</u>		LOCATION (City, town, or county) (State) <u>Bellevue Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-2-56</u>		REGISTRAR'S SIGNATURE <u>N.A. Neer</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS	

UNITED STATES OF AMERICA

1951

WALTER S.
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BUREAU V. S.

JAN 10 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01044

1062

CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>			
CITY (if outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Stevensville</u> <u>17X-2</u>			
40 TOWN <u>Easton</u>		18 da					
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Louis</u> <u>Kelly Jr</u>				<u>1</u> <u>8</u> <u>1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>white</u>	<u>married</u>	<u>December 31, 1903</u>	<u>52</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Custodial officer</u>				<u>Md. House Correction</u>		<u>Maryland</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Mrs Louis Kelly, Sr.</u>				<u>Addie Thomas</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
						<u>Mrs Maie Kelley</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
420.1 IMMEDIATE CAUSE				(A) DUE TO <u>Myocardial Infarct</u>			
ANTECEDENT CAUSE (S):				(B) DUE TO <u>Coronary thrombosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
2							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 21</u> , 19 <u>55</u> , to <u>Jan 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 10</u> , 19 <u>56</u> , and that death occurred at <u>4:20</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>Dr. Schmidt</u>		M. D. <u>Easton</u>		DATE SIGNED <u>8 Jan 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>JAN 10 1956</u>		<u>STEVENSVILLE MD.</u>		<u>STEVENSVILLE, MD.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1-2-56</u>		<u>M. H. Newkirk</u>		<u>Chas. L. Lane</u>		<u>CHURCH HILL, MD.</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 153 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1063

CERTIFICATE OF DEATH

01045

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Talbot Talbot		MARYLAND		STATE Maryland		COUNTY Talbot	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Easton				TOWN St. Michaels,			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital, Easton, Md.				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Charles Kiehl				1 6 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
M	W	Married	3/17/1872	83 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Hotel Owner		Hotel		Germany		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
George K. Kiehl				Katherine Schmoll			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No.				Memorial Hospital, Easton, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
177X IMMEDIATE CAUSE (A) carcinoma-generalized-metastatic						INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
ANTECEDENT CAUSE(S) DUE TO (B) carcinoma-prostate-adenoca.						2+ yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						Generalized cachexia	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7-26-52, to 1-6-56, that I last saw the deceased alive on 1-6-56, and that death occurred at 9:05 PM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, State)		DATE SIGNED	
[Signature]				St. Michaels, Md.		1-7-56	
23. BURIAL, CREMATION, REMOVAL, (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		1/10/56		Willdwood		Williamsport Penna.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
JAN 11 1956		Mrs. N. R. Nevins		Norman D. Marshall		St. Michaels, Md.	

CERTIFICATE OF DEATH

ATTEST: I, REGISTRAR GENERAL OF MARYLAND,

do hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the Department of Health.

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Department of Health at Baltimore, Maryland, this 11th day of January, 1956.

 REGISTRAR GENERAL OF MARYLAND

ATTEST: I, CLERK OF THE DEPARTMENT OF HEALTH,

do hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the Department of Health.

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Department of Health at Baltimore, Maryland, this 11th day of January, 1956.

 CLERK OF THE DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH
 BALTIMORE, MARYLAND

RECEIVED

JAN 11 1956

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JAN 11 1956

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1080

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01046

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH:

COUNTY

TALBOT

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN ST. MICHAELS

LENGTH OF STAY (in this place)

25 YEARS

HOSPITAL OR INSTITUTION OR STREET ADDRESS

00

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md

COUNTY

Talbot

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN St. Michaels

STREET ADDRESS

(If rural give location)

Grace St

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

SAMUEL

WILLARD

LEGG

5. SEX:

MALE

6. COLOR OR RACE:

WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

SINGLE

8. DATE OF BIRTH:

APRIL 11, 1900

4. DATE (Month)

(Day)

(Year)

OF DEATH: JAN

13

1956

9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

55 yrs.

Months

Days

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

TAXI DRIVER

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

St. MICHAELS MD

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME:

WILLIAM B LEGG

14. MOTHER'S MAIDEN NAME:

ELIZABETH MYERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

220-16-9752

17. INFORMANT & ADDRESS:

Mrs. Mary Wright Sherwood Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

IMMEDIATE CAUSE

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

260X

(A)

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

10 hrs.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Diabetes Mellitus

19A. DATE OF OPERATION:

0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) (County) (State)

INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED White ☐ Not white ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-26, 1952 to 1-13, 1956, that I last saw the deceased

alive on 1-13, 1956, and that death occurred at 7:30 PM, from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

Jan 16, 1956

NAME OF CEMETERY OR CREMATORY

Olivet Cemetery

LOCATION (City, town, or county)

St. Michaels, Md

(State)

DATE REC'D BY LOCAL REGISTRAR

1-16-56

REGISTRAR'S SIGNATURE

Mrs. Paul R. Bell

24. FUNERAL DIRECTOR

Stamilton Harrison

ADDRESS

St. Michaels, Md

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 18 1956

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01047

1964

CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Talbot</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Talbot</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>40 Easton</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <i>49 Easton</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) <i>405 North St.</i>	
3. NAME OF DECEASED: (First) <i>Marion</i> (Middle) <i>James</i> (Last) <i>Marshall</i>		4. DATE (Month) (Day) (Year) OF DEATH <i>Jan 25 1956</i>	
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Married</i>	8. DATE OF BIRTH: <i>May 8, 1889</i>
9. AGE last birthday <i>66</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>owner</i>	10B. KIND OF BUSINESS OR INDUSTRY: <i>Lumber</i>	11. BIRTHPLACE (State or foreign country): <i>Maryland (Talbot Co)</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME: <i>James W. Marshall</i>	
14. MOTHER'S MAIDEN NAME: <i>Murphy & Ball</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>218-01-8632</i>		17. INFORMANT & ADDRESS: <i>Edward Marshall</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Coronary Thrombosis</i>			<i>Sudden</i>
ANTECEDENT CAUSE (S) DUE TO <i>Coronary atherosclerotic</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <i>Heart disease</i>			<i>3 yrs</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1954</i> , 19 <i>54</i> , to <i>25</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>1954</i> , 19 <i>54</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Thompson</i>		ADDRESS <i>Carth Maryland</i> DATE SIGNED <i>26 Jan 56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Jan 28, 1956</i>	
NAME OF CEMETERY OR CREMATORY <i>Spring Hill Cemetery</i>		LOCATION (City, town, or county) (State) <i>Easton Maryland</i>	
DATE REC'D BY LOCAL REGISTRAR <i>1-26-56</i>		REGISTRAR'S SIGNATURE <i>N.H. Neerew</i>	
24. FUNERAL DIRECTOR		ADDRESS <i>Maurice E. Newman & Son</i>	

BUREAU V. S.

FEB 6 1956

RECEIVED

1965

CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>		LENGTH OF STAY (in this place) <u>2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>80 Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Catherine</u> <u>Marth</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> <u>19</u> <u>1956</u>			
5. SEX: <u>fe</u>	6. COLOR OR RACE: <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>June 7, 1868</u>	9. AGE last birthday <u>87</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US born</u>	
13. FATHER'S NAME: <u>Michael Corroy</u>				14. MOTHER'S MAIDEN NAME: <u>Anne Haddy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <u>Mrs Helen Ewing (daughters) Easton Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE				(A) MYOCARDIAL RUPTURE			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) ACUTE MYOCARDIAL INFARCTION			
				DUE TO			
				(C) ARTERIOSCLEROTIC + Hypertensive Heart Disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				Instant			
				48 hours			
				years			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1950</u> , to <u>1/19/56</u> , that I last saw the deceased alive on <u>1-19</u> , 19 <u>56</u> , and that death occurred at <u>4:12 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Sheen</u>		M. D. <u>Easton</u>		DATE SIGNED <u>1/24/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Jan 23, 56</u>		<u>Spring Hill</u>		<u>Easton</u>		<u>Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1/20/56</u>		<u>N.H. Newell</u>		<u>Easton</u>		<u>Easton</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

JAN 30 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01049

1966

CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>TALBOT</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Centreville</u> <u>178-2</u>			
TOWN <u>40 EASTON</u>		<u>23 hrs</u>		STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>EASTON Memorial Hosp</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Augusta B. Miller</u>				<u>1 13 1956</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH: <u>Nov. 20 1889</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME: <u>William James Barton</u>				14. MOTHER'S MAIDEN NAME: <u>Lula Jump</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Mrs Naomi B. Brown</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myocardial infarction due</u>						<u>6 hrs</u>	
ANTECEDENT CAUSE (B) <u>atherosclerotic coronary</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>thrombosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1954</u> , to <u>1/13, 1956</u> , that I last saw the deceased alive on <u>1/13, 1956</u> , and that death occurred at <u>6:20 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Thos H. Harrison</u>		ADDRESS <u>Carters Maryland</u>		DATE SIGNED <u>12 Jan 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/15/56</u>		NAME OF CEMETERY OR CREMATORY <u>Centreville Cemetery</u>		LOCATION (City, town, or county) (State) <u>Centreville, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/14/56</u>		REGISTRAR'S SIGNATURE <u>N. H. Newell</u>		24. FUNERAL DIRECTOR <u>Barton Bros. Centreville, Maryland</u>		ADDRESS	

RECEIVED
JAN 24 1956
BUREAU V. S.

WILLYS
CONGRESS
BOND

CERTIFICATE OF DEATH

1981

FILE NO.

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARITAL STATUS

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT

NAME OF OFFICIAL

NAME OF AGENT

NAME OF INSPECTOR

NAME OF SUPERVISOR

NAME OF CHIEF

NAME OF DEPUTY

NAME OF ASSISTANT

NAME OF OFFICIAL

NAME OF AGENT

NAME OF INSPECTOR

NAME OF SUPERVISOR

NAME OF CHIEF

NAME OF DEPUTY

BUREAU V. S.

JAN 11 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN **HOSPITAL:** The law requires that the death certificate be filed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01051

1082

CERTIFICATE OF DEATH

Item 7, Film 191 1-13-56 et

Reg. Dist. No. 291

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Talbot</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Talbot</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN <i>Tilghman</i>		LENGTH OF STAY (in this place) <i>Typ</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Tilghman</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>				STREET ADDRESS (If rural give location) <i>Sherwood Md</i>			
3. NAME OF DECEASED (Type or Print) <i>George</i> (First) <i>Peoples</i> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <i>Jan 9 1956</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Dec. 25, 1913</i>	9. AGE last birthday <i>42</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>		11. BIRTHPLACE (State or foreign country) <i>Skippers Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Peoples</i>				14. MOTHER'S MAIDEN NAME <i>Lula Carpenter</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No.</i>		16. SOCIAL SECURITY NO. <i>228-05-1660</i>		17. INFORMANT & ADDRESS <i>James L. Peoples - Sherwood Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>420.1</i>				18. MEDICAL CERTIFICATION <i>Coronary occlusion</i>			
IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH <i>1 hr 30 min</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1955</i> , to <i>1956</i> , that I last saw the deceased alive on <i>Dec 25</i> , 19 <i>55</i> , and that death occurred at <i>7:30 AM</i> , from the causes and on the date stated above.							
SIGNATURE <i>George Peoples</i>				DATE SIGNED <i>Jan 9 1956</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <input checked="" type="checkbox"/> BURIAL		DATE THEREOF <i>Jan. 12/56</i>		NAME OF CEMETERY OR CREMATORY <i>Diamond Grove</i>		LOCATION (City, town, or county) (State) <i>Skippers Greenville Co, Va</i>	
24. REC'D BY REGISTRAR DATE <i>JAN 11 1956</i>		REGISTRAR'S SIGNATURE <i>Mrs. R. L. Leth</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Norman D. Marshall</i> ADDRESS <i>St. Michael's</i>			

CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1956

DEPT. OF HEALTH

REPORT MADE UNDER DEPARTMENTAL ORDER

INVESTIGATOR

NAME OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PERIOD OF ILLNESS

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

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BUREAU V. S.

JAN 11 1956

RECEIVED

DEPARTMENT OF HEALTH

NOT RECORDED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE VITAL STATISTICS ACT OF 1901, AS AMENDED, AND THE DEPARTMENT OF HEALTH, STATE OF NEW YORK, HAS REVIEWED THE RECORDS OF THE DEPARTMENT OF HEALTH, AND HAS FOUND THAT THE INFORMATION CONTAINED HEREIN IS CORRECT AND COMPLETE.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01052

1067

CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Talbot.</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Talbot.</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN <i>Easton</i>		<i>11 hrs. 24 min.</i>		TOWN <i>Easton</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<i>Memorial Hospital</i>				<i>31 S. Calverton St.</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<i>Nannie Pollard</i>				<i>1 14 1956</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>Female</i>	<i>W.C.</i>	<i>Widowed</i>	<i>Oct. 5 - 1894</i>	<i>61</i> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
						<i>Maryland</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Simon Decker</i>				<i>Louise Chamberlain</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
						<i>Clara Stanley</i>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <i>Hemorrhage, left cerebrum.</i>							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1/13</i> , 1956, to <i>1/14</i> , 1956 that I last saw the deceased alive on <i>1/13</i> , 1956, and that death occurred at <i>5:05 PM</i> , from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS		DATE SIGNED	
<i>Ed Schmidt</i>		<i>Conlon</i>		<i>17 Jan 1956</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>1/17/56</i>		<i>Richard</i>		<i>Easton Md</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>1/16/56</i>		<i>N. H. Neer</i>		<i>James B. Doherty</i>		<i>Easton, Md.</i>	

UNITED STATES OF AMERICA

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

WILLIAM S.
CONGRESS

BUREAU V. S.

JAN 30 1956

RECEIVED

1068

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Talbot</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Talbot</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Easton</i>			
TOWN <i>Easton</i>		<i>12 days</i>		STREET ADDRESS (If rural give location) <i>40</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Memorial</i>				ADDRESS <i>1</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<i>George R. Powderhill</i>				<i>1 14 1956</i>			
5. SEX: <i>M</i>		6. COLOR OR RACE: <i>W</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH: <i>May 22, 1885</i>	
						9. AGE last birthday <i>70</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Mr. Thomas Powderhill</i>				14. MOTHER'S MAIDEN NAME: <i>Mary Heinlein</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>Mrs Margaret Powderhill</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
587.2 IMMEDIATE CAUSE (A) <i>Hemorrhage</i>							
ANTECEDENT CAUSE (S) DUE TO <i>Aneurism of pancreas duct</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>2</i>		19B. MAJOR FINDINGS OF OPERATION					
		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased alive on 19....., and that death occurred at <i>10 AM</i> , from the causes and on the date stated above.							
SIGNATURE <i>Pathologist</i>		M. D. <i>Carlin</i>		DATE SIGNED <i>17 Jan 1956</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		DATE THEREOF <i>JAN. 17, 1956</i>		NAME OF CEMETERY OR CREMATORY <i>SPRING HILL CEMETERY</i>		LOCATION (City, town, or county) (State) <i>EASTON, MD.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>1/16/56</i>		REGISTRAR'S SIGNATURE <i>N. H. Neeruss</i>		24. FUNERAL DIRECTOR <i>W. Hampton Canoll</i>		ADDRESS <i>EASTON, MD.</i>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 24 1956

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01054

1069

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>St Michaels Md.</u> <u>X</u>			
40 TOWN <u>Easton</u>		26 days		STREET ADDRESS (If rural give location) <u>1</u>			
80 HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Aynes</u> <u>Roberts</u>				<u>1</u> <u>18</u> <u>1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>W.</u>	<u>Divorced</u>	<u>Nov 9, 1876</u>	<u>79</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
						<u>Md.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Moses Roberts</u>				<u>Priscilla Adams</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
						<u>Hilda Coleman St Michaels Md</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>						5 wks.	
ANTECEDENT CAUSE (B) <u>Hypertensive Cardiovascular Disease</u>						10 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
0							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/22</u> , 19 <u>54</u> , to <u>1/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/18</u> , 19 <u>56</u> , and that death occurred at <u>3:57 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>R. L. Smith</u>		ADDRESS <u>St. Michaels</u>		DATE SIGNED <u>1-23-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/20/56</u>		<u>St. Michaels</u>		<u>St. Michaels Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1/19/56</u>		<u>N. H. Morris</u>		<u>Norman Marshall</u>			

RECEIVED

JAN 30 1956

BUREAU V. 1

CONGRESS
BOND
GAG

STATE OF NEW YORK
IN SENATE
JANUARY 30, 1956
REPORT OF THE
COMMISSIONER OF THE
DEPARTMENT OF
CORRECTIONS
ON THE
ADMINISTRATION OF
THE DEPARTMENT
DURING THE
YEAR 1955

6100
1955
STATE OF NEW YORK
IN SENATE
JANUARY 30, 1956

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1070 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01055

ITEMS: 3, 8, 9, 10a: film

CERTIFICATE OF DEATH

Reg. Dist. No. 295

1. PLACE OF DEATH: G 192 2-17-56 L				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>45 Easton, Md.</u>		LENGTH OF STAY (in this place) <u>9 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Easton</u> <u>40</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>80 Easton Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>129 S. Washington St.</u>			
3. NAME OF DECEASED: (First) <u>William</u> (Middle) <u>THEODORE</u> (Last) <u>Robinson</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>1 - 30 - 1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>March 29, 1872</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Capt.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired U.S. Capt.</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Theodore F. Robinson</u>				14. MOTHER'S MAIDEN NAME: <u>Helen N. Watkins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs. Alice Robinson (Wife)</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.0</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Congestive Heart Failure</u>						3 mos.	
(B) <u>Arteriosclerotic heart disease</u>						years	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 1952</u> , to <u>Jan. 30, 1956</u> , that I last saw the deceased alive on <u>1-30-</u> 1956, and that death occurred at <u>1:50</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Donald A. Bartley M.D.</u>		M. D. <u>Easton, Md.</u>		DATE SIGNED <u>1-30-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 2, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-30-56</u>		REGISTRAR'S SIGNATURE <u>N.A. Neer</u>		24. FUNERAL DIRECTOR <u>M.E. Newman & Son</u>		ADDRESS <u>Easton</u>	

RECEIVED

FEB 6 1956

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1071

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
40 TOWN <u>Easton</u>		7 days		TOWN <u>Easton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
80 Memorial Hospital				R7D #4			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
Joseph D Spencer				1 9 1956			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
M	W		Oct 26, 1889	66 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Farmer				Maryland		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Mr. Alexander Spencer				Mary Eason			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
				Mrs. Laura M. Spencer			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>Apoplexy</u>							2 days
ANTECEDENT CAUSE (B) <u>A.C.U.D.</u>							5 yrs
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>B.P. 14.</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
1 13/56		B.P. 14. (Mid lobe)					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1954, to 1-9, 1956, that I last saw the deceased alive on 1-9, 1956, and that death occurred at 10:30 A.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS			
M. D.				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Jan 12, 1956		Spring Hill		Easton		MD	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
1-14/56		N.A. Nelson		[Signature]		Easton	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

STATE OF TEXAS, COUNTY OF DALLAS

DATE OF DEATH

DECEASED
 NAME
 SEX
 AGE
 OCCUPATION
 PLACE OF BIRTH
 DATE OF BIRTH
 PLACE OF DEATH
 DATE OF DEATH

CAUSE OF DEATH
 MANNER OF DEATH
 PLACE OF DEATH
 DATE OF DEATH

SIGNATURE OF DECEASED
 SIGNATURE OF WITNESSES
 SIGNATURE OF PHYSICIAN
 SIGNATURE OF CLERK

WITNESSES
 CONGRESS

STATE OF TEXAS, COUNTY OF DALLAS

DECEASED
 NAME
 SEX
 AGE
 OCCUPATION
 PLACE OF BIRTH
 DATE OF BIRTH
 PLACE OF DEATH
 DATE OF DEATH

CAUSE OF DEATH
 MANNER OF DEATH
 PLACE OF DEATH
 DATE OF DEATH

BUREAU V. 2

JAN 17 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01057

CERTIFICATE OF DEATH

Reg. Dist. No. 270

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>TALBOT</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		STATE <u>Maryland</u> COUNTY <u>TALBOT</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>EASTON</u> (<u>Doncaster</u>) <u>40</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>EASTON MEMORIAL</u>		LENGTH OF STAY (in this place) <u>26 hrs</u>		STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>LAURA</u> <u>Spencer</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> <u>13</u> <u>1956</u>			
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>Nov. 12 1889</u>	9. AGE last birthday: <u>66</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>H.W.</u>			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
13. FATHER'S NAME: <u>James Mullikin</u>				14. MOTHER'S MAIDEN NAME: <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs. Bessie Robinson (daughter)</u> <u>Easton Md</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>420.1</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Coronary Thrombosis</u>						3 days	
(B) <u>Arteriosclerotic Coronary Disease</u>						?	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1954</u> to <u>1/13</u> , 1956 that I last saw the deceased alive on <u>1/13</u> , 1956, and that death occurred at <u>12:50</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M. D. <u>Easton Md.</u>		ADDRESS		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>1/15/56</u>		NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		LOCATION (City, town, or county) (State) <u>Easton Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/14/56</u>		REGISTRAR'S SIGNATURE <u>N.A. Nevers</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>Easton</u>	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1083

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01058

Reg. Dist. No. 291

1. PLACE OF DEATH: COUNTY <u>TALBOT</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>ROYAL OAK</u> OR TOWN <u>ROYAL OAK</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>TALBOT</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>ROYAL OAK, MD</u> OR TOWN <u>ROYAL OAK, MD</u> STREET ADDRESS <u>RURAL</u>															
3. NAME OF DECEASED: (Type or Print) <u>WILLIAM T. STANFIELD</u>		4. DATE OF DEATH: (Month) <u>JAN</u> (Day) <u>3</u> (Year) <u>1956</u>		5. SEX: <u>MALE</u>		6. COLOR OR RACE: <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>SINGLE</u>		8. DATE OF BIRTH: <u>AUG 2 1871</u>		9. AGE last birthday: <u>84</u> yrs. <table border="1" style="display: inline-table; font-size: small;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.																		
Months	Days																		
Hours	Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY:				11. BIRTHPLACE (State or foreign country): <u>ROYAL OAK, MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME: <u>CALEB STANFIELD</u>						14. MOTHER'S MAIDEN NAME: <u>MARGARET KERTZ</u>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:				17. INFORMANT & ADDRESS: <u>John Stanfield, Royal Oak, Md</u>											
18. MEDICAL CERTIFICATION																			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>422.1</u> Immediate cause <u>cardiac failure - chronic</u> DUE TO Antecedent cause(s) <u>arteriosclerotic cardiac vascular</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH									
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death: <u>hypertension & d.</u>																			
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:															
21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, office bldg., etc.)				(CITY OR TOWN)				(COUNTY)		(STATE)					
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				HOW DID INJURY OCCUR?											
22. I hereby certify that I attended the deceased from <u>1-11-55</u> , to <u>1-3-56</u> , that I last saw the deceased alive on <u>1-3-56</u> , and that death occurred at <u>2:24 p.m.</u> , from the causes and on the date stated above. SIGNATURE <u>John Stanfield M.D.</u> (DEGREE OR TITLE) <u>St Michaels Md.</u> ADDRESS <u>1-3-56</u> DATE SIGNED																			
23. BURIAL, CREMATION REBURYAL (Specify): <u>Burial</u>				DATE THEREOF <u>Jan 5, 1956</u>				NAME OF CEMETERY OR CREMATORY <u>Springhill Cemetery</u>				LOCATION (City, town, or county) <u>Easton, Maryland</u> (State)							
DATE REC'D BY LOCAL REG. <u>Jan 14, 1956</u>				REGISTRAR'S SIGNATURE <u>Miss Robert R. Self</u>				FUNERAL DIRECTOR <u>St Michaels</u>				ADDRESS <u>St Michaels Md</u>							

BUREAU V. 3

JAN 5 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

01059

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Talbot</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Talbot</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Castor</i>		<i>2 days</i>		TOWN <i>Cordova</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Memorial Hospital</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<i>Baby Boy Steward</i>				<i>1 5 1956</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>M</i>	<i>W</i>		<i>1-3-56</i>	Yrs.	Months <i>2</i>	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<i>Maryland</i>		<i>U.S.A.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>William D. Steward</i>				<i>Nancy Hutchison</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<i>Mr William D Steward</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
7600 IMMEDIATE CAUSE (A)							
<i>Intracranial hemorrhage</i>							
ANTECEDENT CAUSE(S) DUE TO (B)							
<i>Laceration of tentorium</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<i>Congenital Hydrocephalus-nephrosis</i>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<i>2</i>				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<i>W. H. Schmitt</i>				<i>Castor</i>		<i>6 Jun 1956</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<i>1-6-56</i>		<i>Fairview</i>		<i>Cordova, Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>1-6-56</i>		<i>N. H. Neekie</i>		<i>Howard R. Zietman</i>			

2080211373

CERTIFICATE OF DEATH

1003

FILE NO. 1003
Reg. Dist. No. 1003

1. PLACE OF BIRTH

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CLERK

13. SIGNATURE OF JURY

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF DISTRICT ATTORNEY

18. SIGNATURE OF COUNTY CLERK

19. SIGNATURE OF TOWN CLERK

20. SIGNATURE OF VILLAGE CLERK

21. SIGNATURE OF CITY CLERK

22. SIGNATURE OF STATE CLERK

23. SIGNATURE OF NATIONAL CLERK

24. SIGNATURE OF INTERNATIONAL CLERK

25. SIGNATURE OF OTHER CLERK

26. SIGNATURE OF DECEASED

27. SIGNATURE OF WITNESSES

28. SIGNATURE OF PHYSICIAN

29. SIGNATURE OF CLERK

30. SIGNATURE OF JURY

31. SIGNATURE OF JUDGE

32. SIGNATURE OF SHERIFF

33. SIGNATURE OF CORONER

34. SIGNATURE OF DISTRICT ATTORNEY

35. SIGNATURE OF COUNTY CLERK

36. SIGNATURE OF TOWN CLERK

37. SIGNATURE OF VILLAGE CLERK

38. SIGNATURE OF CITY CLERK

39. SIGNATURE OF STATE CLERK

40. SIGNATURE OF NATIONAL CLERK

41. SIGNATURE OF INTERNATIONAL CLERK

42. SIGNATURE OF OTHER CLERK

43. SIGNATURE OF DECEASED

44. SIGNATURE OF WITNESSES

45. SIGNATURE OF PHYSICIAN

46. SIGNATURE OF CLERK

47. SIGNATURE OF JURY

48. SIGNATURE OF JUDGE

49. SIGNATURE OF SHERIFF

50. SIGNATURE OF CORONER

51. SIGNATURE OF DISTRICT ATTORNEY

52. SIGNATURE OF COUNTY CLERK

53. SIGNATURE OF TOWN CLERK

54. SIGNATURE OF VILLAGE CLERK

55. SIGNATURE OF CITY CLERK

56. SIGNATURE OF STATE CLERK

57. SIGNATURE OF NATIONAL CLERK

58. SIGNATURE OF INTERNATIONAL CLERK

59. SIGNATURE OF OTHER CLERK

60. SIGNATURE OF DECEASED

61. SIGNATURE OF WITNESSES

62. SIGNATURE OF PHYSICIAN

63. SIGNATURE OF CLERK

64. SIGNATURE OF JURY

65. SIGNATURE OF JUDGE

66. SIGNATURE OF SHERIFF

67. SIGNATURE OF CORONER

68. SIGNATURE OF DISTRICT ATTORNEY

69. SIGNATURE OF COUNTY CLERK

70. SIGNATURE OF TOWN CLERK

71. SIGNATURE OF VILLAGE CLERK

72. SIGNATURE OF CITY CLERK

73. SIGNATURE OF STATE CLERK

74. SIGNATURE OF NATIONAL CLERK

75. SIGNATURE OF INTERNATIONAL CLERK

76. SIGNATURE OF OTHER CLERK

77. SIGNATURE OF DECEASED

78. SIGNATURE OF WITNESSES

79. SIGNATURE OF PHYSICIAN

80. SIGNATURE OF CLERK

81. SIGNATURE OF JURY

82. SIGNATURE OF JUDGE

83. SIGNATURE OF SHERIFF

84. SIGNATURE OF CORONER

85. SIGNATURE OF DISTRICT ATTORNEY

86. SIGNATURE OF COUNTY CLERK

87. SIGNATURE OF TOWN CLERK

88. SIGNATURE OF VILLAGE CLERK

89. SIGNATURE OF CITY CLERK

90. SIGNATURE OF STATE CLERK

91. SIGNATURE OF NATIONAL CLERK

92. SIGNATURE OF INTERNATIONAL CLERK

93. SIGNATURE OF OTHER CLERK

94. SIGNATURE OF DECEASED

95. SIGNATURE OF WITNESSES

96. SIGNATURE OF PHYSICIAN

97. SIGNATURE OF CLERK

98. SIGNATURE OF JURY

99. SIGNATURE OF JUDGE

100. SIGNATURE OF SHERIFF

101. SIGNATURE OF CORONER

102. SIGNATURE OF DISTRICT ATTORNEY

103. SIGNATURE OF COUNTY CLERK

104. SIGNATURE OF TOWN CLERK

105. SIGNATURE OF VILLAGE CLERK

106. SIGNATURE OF CITY CLERK

107. SIGNATURE OF STATE CLERK

108. SIGNATURE OF NATIONAL CLERK

109. SIGNATURE OF INTERNATIONAL CLERK

110. SIGNATURE OF OTHER CLERK

111. SIGNATURE OF DECEASED

112. SIGNATURE OF WITNESSES

113. SIGNATURE OF PHYSICIAN

114. SIGNATURE OF CLERK

115. SIGNATURE OF JURY

116. SIGNATURE OF JUDGE

117. SIGNATURE OF SHERIFF

118. SIGNATURE OF CORONER

119. SIGNATURE OF DISTRICT ATTORNEY

120. SIGNATURE OF COUNTY CLERK

121. SIGNATURE OF TOWN CLERK

122. SIGNATURE OF VILLAGE CLERK

123. SIGNATURE OF CITY CLERK

124. SIGNATURE OF STATE CLERK

125. SIGNATURE OF NATIONAL CLERK

126. SIGNATURE OF INTERNATIONAL CLERK

127. SIGNATURE OF OTHER CLERK

128. SIGNATURE OF DECEASED

129. SIGNATURE OF WITNESSES

130. SIGNATURE OF PHYSICIAN

131. SIGNATURE OF CLERK

132. SIGNATURE OF JURY

133. SIGNATURE OF JUDGE

134. SIGNATURE OF SHERIFF

135. SIGNATURE OF CORONER

136. SIGNATURE OF DISTRICT ATTORNEY

137. SIGNATURE OF COUNTY CLERK

138. SIGNATURE OF TOWN CLERK

139. SIGNATURE OF VILLAGE CLERK

140. SIGNATURE OF CITY CLERK

141. SIGNATURE OF STATE CLERK

142. SIGNATURE OF NATIONAL CLERK

143. SIGNATURE OF INTERNATIONAL CLERK

144. SIGNATURE OF OTHER CLERK

145. SIGNATURE OF DECEASED

146. SIGNATURE OF WITNESSES

147. SIGNATURE OF PHYSICIAN

148. SIGNATURE OF CLERK

149. SIGNATURE OF JURY

150. SIGNATURE OF JUDGE

151. SIGNATURE OF SHERIFF

152. SIGNATURE OF CORONER

153. SIGNATURE OF DISTRICT ATTORNEY

154. SIGNATURE OF COUNTY CLERK

155. SIGNATURE OF TOWN CLERK

156. SIGNATURE OF VILLAGE CLERK

157. SIGNATURE OF CITY CLERK

158. SIGNATURE OF STATE CLERK

159. SIGNATURE OF NATIONAL CLERK

160. SIGNATURE OF INTERNATIONAL CLERK

161. SIGNATURE OF OTHER CLERK

162. SIGNATURE OF DECEASED

163. SIGNATURE OF WITNESSES

164. SIGNATURE OF PHYSICIAN

165. SIGNATURE OF CLERK

166. SIGNATURE OF JURY

167. SIGNATURE OF JUDGE

168. SIGNATURE OF SHERIFF

169. SIGNATURE OF CORONER

170. SIGNATURE OF DISTRICT ATTORNEY

171. SIGNATURE OF COUNTY CLERK

172. SIGNATURE OF TOWN CLERK

173. SIGNATURE OF VILLAGE CLERK

174. SIGNATURE OF CITY CLERK

175. SIGNATURE OF STATE CLERK

176. SIGNATURE OF NATIONAL CLERK

177. SIGNATURE OF INTERNATIONAL CLERK

178. SIGNATURE OF OTHER CLERK

179. SIGNATURE OF DECEASED

180. SIGNATURE OF WITNESSES

181. SIGNATURE OF PHYSICIAN

182. SIGNATURE OF CLERK

183. SIGNATURE OF JURY

184. SIGNATURE OF JUDGE

185. SIGNATURE OF SHERIFF

186. SIGNATURE OF CORONER

187. SIGNATURE OF DISTRICT ATTORNEY

188. SIGNATURE OF COUNTY CLERK

189. SIGNATURE OF TOWN CLERK

190. SIGNATURE OF VILLAGE CLERK

191. SIGNATURE OF CITY CLERK

192. SIGNATURE OF STATE CLERK

193. SIGNATURE OF NATIONAL CLERK

194. SIGNATURE OF INTERNATIONAL CLERK

195. SIGNATURE OF OTHER CLERK

196. SIGNATURE OF DECEASED

197. SIGNATURE OF WITNESSES

198. SIGNATURE OF PHYSICIAN

199. SIGNATURE OF CLERK

200. SIGNATURE OF JURY

201. SIGNATURE OF JUDGE

202. SIGNATURE OF SHERIFF

203. SIGNATURE OF CORONER

204. SIGNATURE OF DISTRICT ATTORNEY

205. SIGNATURE OF COUNTY CLERK

206. SIGNATURE OF TOWN CLERK

207. SIGNATURE OF VILLAGE CLERK

208. SIGNATURE OF CITY CLERK

209. SIGNATURE OF STATE CLERK

210. SIGNATURE OF NATIONAL CLERK

211. SIGNATURE OF INTERNATIONAL CLERK

212. SIGNATURE OF OTHER CLERK

213. SIGNATURE OF DECEASED

214. SIGNATURE OF WITNESSES

215. SIGNATURE OF PHYSICIAN

216. SIGNATURE OF CLERK

217. SIGNATURE OF JURY

218. SIGNATURE OF JUDGE

219. SIGNATURE OF SHERIFF

220. SIGNATURE OF CORONER

221. SIGNATURE OF DISTRICT ATTORNEY

222. SIGNATURE OF COUNTY CLERK

223. SIGNATURE OF TOWN CLERK

224. SIGNATURE OF VILLAGE CLERK

225. SIGNATURE OF CITY CLERK

226. SIGNATURE OF STATE CLERK

227. SIGNATURE OF NATIONAL CLERK

228. SIGNATURE OF INTERNATIONAL CLERK

229. SIGNATURE OF OTHER CLERK

230. SIGNATURE OF DECEASED

231. SIGNATURE OF WITNESSES

232. SIGNATURE OF PHYSICIAN

233. SIGNATURE OF CLERK

234. SIGNATURE OF JURY

235. SIGNATURE OF JUDGE

236. SIGNATURE OF SHERIFF

237. SIGNATURE OF CORONER

238. SIGNATURE OF DISTRICT ATTORNEY

239. SIGNATURE OF COUNTY CLERK

240. SIGNATURE OF TOWN CLERK

241. SIGNATURE OF VILLAGE CLERK

242. SIGNATURE OF CITY CLERK

243. SIGNATURE OF STATE CLERK

244. SIGNATURE OF NATIONAL CLERK

245. SIGNATURE OF INTERNATIONAL CLERK

246. SIGNATURE OF OTHER CLERK

247. SIGNATURE OF DECEASED

248. SIGNATURE OF WITNESSES

249. SIGNATURE OF PHYSICIAN

250. SIGNATURE OF CLERK

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN

HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR:

The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01060

1074

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Easton</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Royal Oak</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Highway</u>				STREET ADDRESS (If rural give location) <u>Box 196</u>		1	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Alfred Coxen Thomas</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1 13 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>3/9/34</u>	9. AGE last birthday <u>24</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumberman</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert Woodland Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Mildred Coxen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Mildred Coxen</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
816X IMMEDIATE CAUSE (A) <u>Multiple fractures</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Auto accident</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>UNDERLYING CAUSE LAST.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Highway</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Easton Talbot Md</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>20 1 13 56 1956</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Drove car into road grader</u>			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>56</u> , to <u>Jan</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 13 1956</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Louis W. DME</u>		ADDRESS (Street, city, town, state) <u>Easton Md</u>		DATE SIGNED <u>1-14-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>1/16/56</u>	NAME OF CEMETERY OR CREMATORY <u>Royal Oak Cem.</u>		LOCATION (City, town, or county) (State) <u>Royal Oak Md.</u>			
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <u>N. H. Newry</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Cahill</u>		ADDRESS <u>Easton, Md.</u>			
DATE <u>1/14/56</u>							

The bottom copy may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

1957

1. DECEASED'S NAME (Last, first, middle initial)

MARYLAND
DIVISION OF DEATH
REGISTRATION

2. DATE OF DEATH (Month, day, year)

3. PLACE OF DEATH (City, town, village, or county)

4. SEX (Male or Female)

5. AGE (Years, months, days)

6. OCCUPATION

7. CAUSE OF DEATH (Immediate cause, underlying cause, and contributing causes)

8. MANNER OF DEATH (Natural, accident, homicide, suicide, or undetermined)

9. SIGNATURE OF PHYSICIAN (Name and title)

10. SIGNATURE OF REGISTRAR (Name and title)

11. SIGNATURE OF WITNESSES (Name and address)

12. SIGNATURE OF CORONER (Name and title)

13. SIGNATURE OF JURY (Name and title)

14. SIGNATURE OF JUDGE (Name and title)

15. SIGNATURE OF CLERK (Name and title)

16. SIGNATURE OF NOTARY (Name and title)

17. SIGNATURE OF DECEASED'S NEXT OF KIN (Name and address)

18. SIGNATURE OF DECEASED'S ESTATE (Name and address)

19. SIGNATURE OF DECEASED'S CREDITOR (Name and address)

20. SIGNATURE OF DECEASED'S LEGAL REPRESENTATIVE (Name and address)

21. SIGNATURE OF DECEASED'S SURVIVOR (Name and address)

22. SIGNATURE OF DECEASED'S FRIEND (Name and address)

23. SIGNATURE OF DECEASED'S NEIGHBOR (Name and address)

24. SIGNATURE OF DECEASED'S RELATIVE (Name and address)

BUREAU V. S.

JAN 24 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01061

1084

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>TALBOT</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Wittman</u>			
X TOWN <u>WITTMAN</u>		<u>LIFE</u>		STREET ADDRESS (If rural give location) <u>1</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <u>WELBY</u> <u>WILLEY</u>				DATE OF DEATH: <u>Jan 14</u> <u>1956</u>			
5. SEX: <u>MALE</u>		6. COLOR OR RACE: <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>AUG 26-1899</u>	
9. AGE last birthday <u>58</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>ST. MICHAELS Md</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. IF UNDER 1 YEAR Months Days Hours Mln.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>WATERMAN</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>SEAFOOD</u>			
13. FATHER'S NAME: <u>CHARLES WILLEY</u>				14. MOTHER'S MAIDEN NAME: <u>JULIAN GODWIN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NONE</u> <u>NONE</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS: <u>Mrs Welby Willey, Wittman Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH—							
199.1 IMMEDIATE CAUSE						3 yrs	
ANTECEDENT CAUSE (S)						4 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 14, 1956</u> to <u>Jan 14, 1956</u> that I last saw the deceased alive on <u>Jan 14, 1956</u> and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>John H. Willey</u>		ADDRESS <u>Talbot County, Md.</u>		DATE SIGNED <u>Jan 17, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/17/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cemetery</u>		LOCATION (City, town, or county) (State) <u>St. Michaels, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 17, 1956</u>		REGISTRAR'S SIGNATURE <u>Mrs. Robert L. Scott</u>		24. FUNERAL DIRECTOR <u>St. Michaels</u>		ADDRESS <u>St. Michaels, Md.</u>	

RECEIVED

JAN 18 1956

BUREAU V. S.